

**McLEOD MEDICAL CENTER  
PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI \_\_\_\_\_ Male/Female \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Driver's License # \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Employer Phone# \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ Spouse SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer: \_\_\_\_\_ Employer's Phone # \_\_\_\_\_  
Nearest Relative/Friend \_\_\_\_\_ Relation \_\_\_\_\_ Phone# \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (IF OTHER THAN ABOVE)**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Phone # \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_  
Subscriber SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_\_  
Subscriber SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**AUTHORIZATION & AGREEMENT BY PATIENT**

*All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance coverage. It is customary to pay for services when rendered unless arrangements are made in advance. Please **READ** and **SIGN** the following authorization and assignment.*

*I hereby authorize McLeod Medical Center to furnish information to insurance carriers concerning my illnesses and treatments, and I hereby assign to McLeod Medical Center all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by my insurance.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**McLEOD MEDICAL CENTER**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ acknowledge that I have received a copy of McLeod Medical Center's "**NOTICE OF PRIVACY PRACTICES**". This notice describes how McLeod Medical Center may use and disclose my protected health information, and rights that I have regarding my protected health information.

I have also been offered a copy of McLeod Medical Center's "**Notice of Advanced Directives**" and I have accepted or declined to fill out the Advanced Directives forms and have them included in my chart.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

**AUTHORIZATION OF ASSIGNMENT OF BENEFITS, RELEASE OF  
INFORMATION AND CONSENT FOR TREATMENT:**

I hereby authorize payment directly to MCLEOD MEDICAL CENTER for services rendered and supplies provided by MCLEOD MEDICAL CENTER. I understand that this assignment is for all benefits otherwise payable to me, but not to exceed my indebtedness to said Clinic. I authorize MCLEOD MEDICAL CENTER to release any information acquired in the course of treatment or examination. I understand that I am financially responsible to MCLEOD MEDICAL CENTER for charges not covered by this assignment. I authorize the release of any and all medical information necessary to process these claims and I request payment of any benefits due me or for my benefit to be made directly to MCLEOD MEDICAL CENTER.

I hereby authorize and consent to be treated by MCLEOD MEDICAL CENTER physicians and staff. The undersigned consents to any X-Ray, examination, laboratory procedures, anesthesia, minor surgical procedures or any medical services rendered under the general or specific instructions of the MCLEOD MEDICAL CENTER physicians. The undersigned recognizes that some persons furnishing professional medical services, including but not limited to radiology and pathology, may independent contractors and not employees or agents of the Clinic.

**AGE OF CONSENT—WHERE MINORS ARE INVOLVED, THE FOLLOWING  
SHALL PREVAIL:**

- 1) The consent of parent or legal guardian if patient is unmarried and has not yet attained the age of (18).
- 2) If a patient under (18) years of age is married, or has been married and such marriage has been dissolved by dissolution or annulment, then the consent of a parent or legal guardian is not required.

The undersigned hereby acknowledges that he or she has read and fully understands the foregoing, and has voluntarily executed this document. The undersigned further acknowledges that he or she is the patient, or is duly authorized by and on behalf of the patient to execute this document, and accepts its terms personally and upon the patient's behalf. The release of information set forth herein above is valid, and the assignment of benefits and financial agreement is valid and binding until final settlement of the account is received.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_